# POWER OF ATTORNEY WORKSHEET

**PRIVACY ACT STATEMENT (5 USC 552a)**

**AUTHORITY:** Title 10 USC, Section 3012.

**PRINCIPAL PURPOSE:** To assist a Legal Assistance Attorney with the preparation of legal documents for you

**ROUTINE USE(S):** To provide basic information necessary in preparation of such documents. Only Family Care Plan legal documents will be placed in your Personnel Readiness Folder.

**MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL NOT PROVIDING INFORMATION:** Voluntary Failure to disclose the requested information will result in a Legal Assistance Attorney not being able to prepare the document for you.

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A Legal Assistance Attorney requires certain information to prepare powers of attorney. Remember that a power of attorney is a potent document. It should be no broader than is required to meet existing needs. However, a general power of attorney will be provided if desired.

1. Your name: _____ 2. SSN: _____

3. Your address: _____

4. What county is your address in: _____

5. Name of your proposed "attorney-in-fact"
(Person you are giving the power to): _____

6. Address of your "attorney-in-fact": _____

_____

7. Do you desire: Check Box Option
a general power of attorney: _____ or a special power of attorney: _____

8. If "special" what power so you want your attorney-in-fact to have (check those appropriate): Check Box for All Option

_____ File or extend taxes _____ Endorse, cash, deposit checks

_____ Sell personal property: Describe property to be sold (i.e. 1987 Ford Escort)

_____

_____

_____ Sell Real Property: Describe the real property. Legal description is best, but at least a street address is necessary.

_____

_____

_____ Other power: _____

_____

_____

**FOR DEPENDENT CARE USE SDNG FORMS 600-20-R (Jul 90) AND 600-21-R (Jan 90)**

SDNG Form 27-3[illegible] (Mar 90)

# SOUTH DAKOTA NATIONAL GUARD
# YOUTH PROGRAM
## VOLUNTEER AGREEMENT

The intent of this agreement is to assure you of our deep appreciation of your services and to indicate our commitment to do our very best to make your volunteer experience productive and rewarding with the South Dakota National Guard Youth Program.

**YOUTH VOLUNTEER.**

I, _____, agree to serve as a volunteer and understand that I am not, solely because of these services, an employee of the United States Government, State of South Dakota Government or any instrument thereof, except for certain purposes relating to tort claims and workman's compensation coverage with regard to incidents occurring during the performance of approved volunteer services. I will report any injury or incident immediately to the State Youth Coordinator. I agree that I expect no present or future salary, wages or benefits as payment for these volunteer services.

***State Youth Program agrees to:***

***Provide training.**
***Provide job description.**
***Provide assistance, support and encouragement.**
*** Provide information on upcoming events & training.**
***Provide a safe environment.**

***Youth Volunteer agrees To:***

***Perform volunteer duties professionally.**
***Participate in youth activities,conferences, meeting.**
***Honor confidentiality of National Guard service and family members.**
***Adhere to National Guard Youth Program Code of Conduct.**
***Participate in training to improve knowledge and skills.**

**AGREE TO:** This agreement may be canceled at any time upon verbal or written notification to the State Family Readiness Youth Coordinator.

_____ Electronic Signature
Volunteer — Family Readiness Youth Coordinator

Drop Down Box — Drop Down Box
Date — Date

**I have read the above form and grant permission for my child to volunteer and receive newsletters and emails from the South Dakota National Guard Youth Program.**

_____
**Parent's Signature**

_____
**Date**

The following information is needed for requesting invitational travel orders, youth mailings, requesting information and for youth e-mail distribution letters.

Social Security Number (for order information)

Street or PO Box (mailing address)

City State Zip

E-Mail Address

**SOUTH DAKOTA NATIONAL GUARD**
**YOUTH PROGRAM**
**2823 West Main St. Bldg 520**
**Rapid City, SD 57702**
**1-800-658-3930**

(CERTIFICATE)

UNIFORM MAINTENANCE ALLOWANCE STATEMENT

1. The officer(s) listed below has (have) performed four years of satisfactory Federal Service as prescribed in Title 10, United States Code, Section 1332 (formerly Title III of the Army and Air Force Vitalization and Retirement Equalization Act of 1948, as amended), and as set forth in paragraph 80332, DODPM.

2. The four years of satisfactory Federal Service included 28 days of active duty or active duty for training.

3. The duty required the wearing of the uniform.

4. The four years of duty performed were exclusive of any period on continuous active duty or active duty for training in excess of 90 days, and of any period of active duty or active duty for training of less than 90 days entered upon pursuant to orders for a period in excess of 90 days.

5. A period of not less than four years from the date of intitlement to the last uniform reimbursement or allowance has elapsed for each officer listed.

6. The officer(s) has (have) not received the uniform maintenance allowance for the four year period of satisfactory Federal Service on which this claim is based.

| NAME | GRADE | SSN | PERIOD OF ENTITLEMENT (DATES) FROM: | TO: | *DATE OF LAST ENTITLEMENT TO UNIFORM REIMBURSEMENT OR ALLOWANCE AND TYPE OF ALLOWANCE |
|---|---|---|---|---|---|
| | | | | | |

Electronic Signature
(Signature of Commanding Officer)

_____
(Organization)

*If not applicable, leave blank.

SDNG Form 29[illegible] (29 Jun 92)

# STATEMENT IN LIEU OF CURRENT MEDICAL EXAMINATION

I, The undersigned, do hereby certify that I underwent a complete medical examination for military service on or about Drop Down Box *(Date)* accomplished by

_____ *(Name of physician or military installation)* and since that time:

Check BOX option

☐ I have not been treated by clinics, physicians, healers, or other practioners.

☐ I have been treated by _____ *(Name of physician)*

_____ *(Diagnosis)* from _____ *(Date)* to _____ *(Date)*

☐ I was hospitalized in _____ *(Name of hospital)* from _____ *(Date)*

to _____ *(Date)* The diagnosis _____

My attending physician was _____

Check Box option

I ☐ do ☐ do not believe that I am now medically qualified to perform satisfactory military service.

The following is my current height and weight.

Height: Drop down Box

Weight: Drop down Box

_____ *(Printed name, Rank, SSAN)*

_____ *(Unit and State)*

Electronic Signature *(Signature)*

Drop down Box *(Date)*

SDNG Form 30[illegible] (1 JUN 01)

UNIT HEADING

SUBJECT: Request for Payment of Incapacitation Pay Drop Down Box (Date)

THRU CHANNELS

TO: The Adjutant General
State of South Dakota
ATTN: SDADA
2823 West Main Street
Rapid City, SD 57702-8186

1. Request that Incapacitation Pay for _____ (Grade and Name)
_____ (SSN) be approved from Drop Down Box (date) thru Drop down Box (date).
_____ (injury or diesease) incurred in Line of Duty on Drop Down Box (date) while undergoing _____ (type of trng: AT, FTTD, IDT; and NS Code).

2. Individual is expected to return to normal military duty by Drop Down Box (date).

A copy of Physicians Statement SDNG Form 37-3 with expected return date is provided as Inclosure 1.

3. A complete narrative report from the attending physician to include a definite medical diagnosis of the disability, type of medical treatment furnished and the nature of the healing process is provided in Inclosure 1.

4. The individual was hospitalized during the following period(s) (if any):
Drop Down Box (date admitted) _____ (date released)

5. Previous payments have/have not been processed for period(s) Drop Down Box (date) through Drop Down Box (date) for this disability.

6. The individual has/has not attended Drop Down Box training since
(type AT, IDT, FTTD)

this disability. A Commanders Statement (SDNG Form 37-2) is provided in Inclosure 3.

7. Individual's MOS/SSI and Title at time of disability was _____

_____.

8. Individual s civilian occupation is _____.
(position)

and is employed by _____ located at _____.
(firm) (city)

Drop Down Box Individual has/has not returned to work since Drop Down Box.
(state) (date)

Electronic Signature
(Commander's Signature)

## COMMANDER'S STATEMENT

I certify that the injury or disease of _____
(Name)

_____
(grade, SSN, and Unit)

has in fact incapacitated the individual from performing the normally assigned military duties of the MOS/SSI during the period from Drop Down box
(date)

thru Drop Down Box.
(date)

Individual has/has not attended training.

Dates of training attended in a limited duty status Drop Down Box thru
(date)

Drop Down Box.
(date)

Electronic Signature
(Commander's Signature)

# PHYSICIANS STATEMENT

Note to attending physician: Please complete your portion of this statement to determine if the Guardmember is in fact incapacitated to the extent that he/she cannot perform his/her normal military duties. To help you make that determination, the individual's normal military duties are outlined below.

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UNIT COMPLETE

SECTION 1 (To be completed by unit prior to submission to physician)

Normal military duties for _____ (Name, Rank, SSN)

consist of the following: _____

_____

_____

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PHYSICIAN TO COMPLETE

SECTION 2 (To be completed by attending physician.)

On Drop Down Box (date) I examined and found that _____ (Name and rank)

_____ (SSN) (was/was not) disabled for the performance of his/her military duties during the period from Drop Down Box (date) thru Drop Down Box (date) due to _____ (Diagnosis)

_____

_____

_____

_____

_____

Please complete one of the following as applicable:

*1. Estimated duration of incapacitation Drop Down Box (date)

2. Service member is fit for normal military duty on Drop Down Box (date)

_____
(Physician's typed name & signature)

_____
(Address and date)

*NOTE: Date - Do not use "Unknown"; must use day, month, year

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SDNG FORM 37-3 (29 Jun 92) Previous Edition Obsolete

Soldier Claim Form

Drop Down Box

1. I hereby certify that I (incurred) (aggravated) the following (injury:) (illness:) (disease:) Drop Down Box in the line of duty, while (participating in military training) (traveling directly (to) (from) military training).

* 2. I further certify that as a result of the above described (injury) (illness) (disease), I suffered a loss of $_____ of non-military (civilian) income during the period _____ to _____(period may only be one calendar month or less for each statement). In the period I received $_____ in gross income from (my employer) (self-employment) (dual employment) for that portion of the month I worked.

** 2. I further certify that I am unemployed at present, without income from any source, including, but not limited to, unemployment compensation, social security, workman's compensation or Veteran's Administration payments. If I become employed, while receiving incapacitiation pay, I understand it will be my responsibility to notify my unit and/or commander to ensure military pay and allowances will be reduced by the income being received at that time.

* 3. My claim is substantiated by the enclosed letter(s) from my employer(s).

*** 3. I am self-employed and in order to substantiate my claim of lost non-military income for the period cited in paragraph 2 above, I have enclosed a copy of my latest IRS Form 1040, with supporting documents, including Schedule C.

*/**/*** 4. In addition, I certify that I received $_____ from an income protection plan (including sick leave, etc). (Note: if the soldier does not have sick leave, vacation pay, or another income protection insurance pay, he/she must so state).

5. I further certify that the information which I have provided regarding this claim is correct. I understand that the penalty for knowingly and willfully making a false claim or a false statement in connection with a claim is a fine of up to $10,000 or imprisonment for up to 5 years or both (18 USC 287, 1001).

6. I hereby waive my VA compensation if eligible. DA Form 3053 and VA Form 21-8951 are enclosed. (Submit only one time).

7. Privacy Act statement is enclosed.

Drop Down Box Electronic Signature
Date Soldier's Signature and Social Security Number

PHONE #_____ HOME ADDRESS: _____

UIC _____

_____
CITY STATE

* Mandatory for soldiers who are employed.
** Mandatory for soldiers who are unemployed.
***Mandatory for soldiers who are self-employed.

SDNG Form 37-5[illegible] (29 Jun 92) (Replaces SDNG FORM 37 - SERVICE MEMBER STATEMENT)